Cleverley + Associates

A response to the FY19 IPPS Proposed Rule (CMS-1694-P) for Requirements for Hospitals to Make Public a List of Their Standard Charges via the Internet

Provided by: Cleverley + Associates

BACKGROUND

The FY19 IPPS Proposed Rule contains a section for requirements for hospitals to make public a list of their standard charges via the internet. This section of the proposed rule revisits a reminder contained in the FY15 IPPS Proposed Rule and ultimately the initial calls for transparency in the Affordable Care Act (specifically, 2718(e) of the Public Health Service Act). That language required hospitals to "either make public a list of their standard charges (whether that be the chargemaster itself or in another form of their choice) or their policies for allowing the public to view a list of those charges in response to an inquiry."

It is no surprise that the CMS is attempting to continue this national dialogue as many providers still struggle with how to effectively improve price transparency. In fact, our firm has conducted national provider surveys on how hospitals are approaching price transparency and the areas that tend to receive the most price inquiries from patients. The results of those surveys have been transferred into HFMA-related publications. What we've found is that the vast majority of hospitals are complying with the ACA transparency language by providing a means for patients to request pricing information – but not – through public display of pricing information via a website or some other form.

As a result, the FY19 IPPS Proposed Rule indicates that as of January 1, 2019 guidelines will be updated to require hospitals to make prices available via the internet. In addition, the proposed rule requests input on several price transparency definitions, methods, and measures. The purpose of this paper is to provide hospitals with language that can be used to respond to the CMS. We have submitted this as an official comment, however, we believe multiple voices should be heard so we are providing our thoughts as a resource.

RESPONSE TO THE GUIDELINE CHANGE

We thank the CMS for continuing the national dialogue on price transparency through inclusion of language to make price information more available to the public. Specifically, the language in the FY2018 IPPS Proposed Rule (CMS-1694-P) states:

> *"We are concerned that challenges continue to exist for patients due to insufficient price transparency. Such challenges include patients being surprised by out-of-network bills for physicians, such as anesthesiologists and radiologists, who provide services at in network hospitals, and patients being surprised by facility fees and physician fees for emergency room visits. We also are concerned that chargemaster data are not helpful to patients for determining what they are likely to pay for a particular service or hospital stay. As one step to further improve the public accessibility of charge information, effective January 1, 2019, we are updating our guidelines to require hospitals to make available a list of their current standard charges via the Internet in a machine-readable format and to update this information at least annually, or more often as appropriate. This could be in the form of the chargemaster itself or another form of the hospital's choice, as long as the information is in machine readable format."*

While making this information available on the internet would provide price information to the public, **we strongly believe that this guideline change will not improve the public's ability to understand price information for most patient encounters nor will it address the main concerns listed by the CMS for including this guideline.**

First, let us consider the challenges listed in the FY19 proposed rule for prompting the new hospital charge requirement:

1) Out-of-network bills for physicians
2) Additional physician fees for emergency visits

Both of these primary challenges are not addressed by the guideline "*to require hospitals to make available a list of their current standard charges via the Internet in a machine readable format.*"

Further, this guideline stands in contrast to the proposed rule language that "*chargemaster data are not helpful to patients for determining what they are likely to pay for a particular service or hospital stay.*" We agree with this statement and we are not alone. In fact, in a survey regarding price transparency policies that received feedback from 78 finance leaders representing 185 hospitals the vast majority indicated that creating meaningful and relevant information out of pricing data is the greatest challenge to creating greater pricing transparency (Houk, S., Cleverley, J. "How hospitals approach price transparency." *Hfm,* Sep. 2014, pp. 57-62).

We do, however, want to present what we believe are the specific obstacles to making relevant charge information available to the public. Ultimately, there are two basic forms of providing price information – at the unit level and at the encounter level. Both have significant challenges to public disclosure:

1) **Price per unit (Chargemaster, procedure code, etc. pricing)**
   Pricing at the unit level, whether that is a list of prices at the chargemaster code and/or procedure code would be the easiest for hospitals to provide, however, it is likely to be the most irrelevant for patients.

   a. **Price per unit is misleading because of varying degrees of bundling at different hospitals**
      A goal of price transparency is the ability to compare prices across providers so that patients can make informed decisions. However, at the procedure code level, pricing across providers can include differing levels of associated services and supplies. One provider could charge individually for all items received in care while another could bundle some of those services and supplies into a packaged price. As a result, comparing prices at the procedure code level will be misleading to patients.

   b. **Per unit pricing is misleading because it is only one part of a patient's total encounter charges**
      For many patient encounters, the patient claim will consist of a variety of services. Those individual services will have established prices that will be consistently priced for all payers. However, the value of publicizing the prices for these individual services (at the chargemaster and/or procedure code level) would be greatly diminished because the frequency of use for those services cannot be known until the patient's care is delivered – uniquely for what that specific patient requires.

2) **Price per encounter (MSDRG, Primary APC, etc. pricing)**
Ultimately, this level of charge information would be preferable for a patient because it would provide a better understanding of total charges for the patient's encounter at the hospital. There are key obstacles to this level of price transparency, as well:

   a. **Significant charge variation can exist in "similar" patient encounters**
   If charges were grouped by MSDRG or primary APC there can still be significant variation in average charge levels across patients due to the different types of individual services provided and the frequency and duration of service. This could be mitigated somewhat with some statistical measures to help patients understand the magnitude of variation, but, is still a challenge.

   b. **Patients rarely understand the encounter group their service will fall into prior to receiving treatment – and likely would not understand the group after**
   Our industry has created groups of related cases for the purposes of payment. However, the naming conventions and different levels of service ("w/ CC" or "Level 3" as examples for inpatient and outpatient levels) are not patient friendly. So, the patient struggles to know what to select and to even understand what would be included in that economic grouping. Further, for many patients they will generally have no idea what their encounter will be. In fact, for many, unless the treatment is planned and elective, there would be no benefit in even knowing this information in advance.

Beyond the reasons above, however, the greatest challenge to publicizing gross charge information to the public is that this information is ultimately not what the patient wants to know. Patients are interested in their out-of-pocket payments for services. Disclosing individual code prices or average encounter-grouped claim charges will not help patients and will likely lead to even greater confusion and frustration.

Where does this leave us? Can we simply say the obstacles are too large to overcome? No. We respect the CMS for trying to continue this dialogue and offer the following resources and ideas as next steps in continuing to improve price transparency:

1) **Insurers are best positioned to provide relevant patient payment information**
Ultimately, patients are interested in knowing what their service is going to cost them. Even if hospital charges could be known and provided in advance for the patient to view, that information might not produce any meaningful information for the patient because their insurer's agreement with the provider would discount those charges to a different level for the patient. Many insurers are already helping their members understand specific payment responsibilities based on their offerings, agreements with providers, and how the patient's utilization of service with other providers would impact copayment and deductible amounts. In the end, gross charge information could be very misleading to a patient, but, patient responsibility information provided by their insurer will be of most benefit. Insurers are best positioned to provide this as the agreements with their members – and their members' utilization of other healthcare services – will change frequently and result in continued impact to patient responsibility.

2) **Enhanced communication of the patient billing process is needed**
The primary challenges cited for requiring hospitals to post charges – surprising physician bills

for associated hospital service – are not solved through posting hospital charges but rather through better communication of the billing process. Our industry needs to better communicate that there could be professional billing components for care that is not covered by the hospital's fees. Many hospitals are developing these strategies to make the complex healthcare environment less frustrating to our patients. As these strategies unfold, we should look for best practices to implement nationally.

3) **We should build on established best practices**
As an industry, we continue to pursue policies that will improve transparency. As an example, the Healthcare Financial Management Association (HFMA) has established guiding policies for hospitals to adopt in the creation of more transparent pricing (https://www.hfma.org/transparency/) and many hospitals are using these to continue to improve. We believe steps are being taken to address the ACA language to make pricing more transparent. However, the CMS FY15 proposed rule stated that "MedPAC suggested that hospitals be required to CMS-1607-F 1205 post the list on the Internet, and while we agree that this would be one approach that would satisfy the guidelines, we believe hospitals are in the best position to determine the exact manner and method by which to make the list public in accordance with the guidelines." We hold that this belief is still true today – that hospitals are best positioned to determine how to make this information public.

In sum, we strongly believe the proposed guideline to make public a list of hospital charges in machine readable format available on the internet will not address the challenges the CMS has provided. Rather, the guideline would lead to greater confusion for patients trying to determine what impact their service will have for them personally. While hospitals will continue to help make charge information more accessible to patients, subject to the provisions of section 2718(e) of the Public Health Service Act, we hold that insurers are best suited for providing patients with the information they have most interest in understanding: individual payment responsibility.

RESPONSES TO QUESTIONS

QUESTION: Should "standard charges" be defined to mean: average or median rates for the items on the chargemaster; average or median rates for groups of services commonly billed together (such as for an MS-DRG), as determined by the hospital based on its billing patterns; or the average discount off the chargemaster amount across all payers, either for each item on the chargemaster or for groups of services commonly billed together? Should "standard charges" be defined and reported for both some measure of the average contracted rate and the chargemaster? Or is the best measure of a hospital's standard charges its chargemaster?

> *Standard charges are chargemaster charges – but – this information would not be useful to patients. Chargemasters typically contain thousands of lines and are difficult to navigate. An MSDRG or primary APC grouping could be used, but, patients wouldn't understand what category their treatment would fall into as clinical descriptions provided by physicians often don't coincide with the economic categories we've created for payment purposes. Also, the patient might not understand what level of comorbidity or complications the patient visit might contain that could alter average charges significantly. Procedure-code charges are also problematic because of the level of bundling that can occur and the misrepresentation of what series of services the patient might experience for their treatment. Our earlier response addresses this in more detail.*

QUESTION: What types of information would be most beneficial to patients, how can hospitals best enable patients to use charge and cost information in their decision-making, and how can CMS and providers help third parties create patient-friendly interfaces with these data?

> *Ultimately, patients are interested in understanding their payment. To address this need, insurers are deploying tools for members to understand their payment responsibilities for treatment and insurers will be best suited to continue to provide this information to patients.*

QUESTION: Should health care providers be required to inform patients how much their out-of- pocket costs for a service will be before those patients are furnished that service? What changes would be needed to support greater transparency around patient obligations for their out-of-pocket costs? What can be done to better inform patients of these obligations? Should health care providers play any role in helping to inform patients of what their out-of- pocket obligations will be?

> *Out-of-pocket expenses are best addressed by insurers as they will have the most current payment amounts, including deductible and copayment information, for members.*

QUESTION: Should we require health care providers to provide patients with information on what Medicare pays for a particular service performed by a health care provider? If CMS were to finalize a requirement that this information be made available to beneficiaries by health care providers, what changes would need to be made by health care providers? What corresponding regulatory changes would be necessary?

> *Presenting patients with Medicare payment information for similar services would pose significant challenges and be detrimental to providers. This requirement should NOT be pursued. Among the primary reasons are, as follows:*

1) *Providers would need to run patient claims through a Medicare pricer to determine what the payment would have been for that claim. This would increase the cost of administration and delay the timeliness of payment for providers – imposing a significant financial burden.*
2) *Patients would be confused as to which amount they were expected to pay and could contact the provider, their insurer, or the CMS with questions as to the provision of this information.*
3) *Payment for certain women's and children's oriented services could be disputed for relevance given the lower volume of cases.*
4) *The adequacy of Medicare and commercial payment levels could prompt confusion and frustration. For example, the March 2018 Medpac "Report to the Congress: Medicare Payment Policy" reported that the aggregate hospital margin for Medicare services was -9.6% in 2016. The annual State of the Hospital Industry publication, by Cleverley + Associates, has consistently shown that overall hospital margins are roughly 4% per year. Given this, it is commonly understood in our industry that commercial payers are covering for margin deficiencies for governmental payers. Explaining this to patients would impose significant burdens by all parties.*

CMS is considering making information regarding noncompliance with section 2718(e) of the Public Health Service Act public and intends to consider this as well as additional enforcement mechanisms in future rulemaking. Therefore, we are seeking comment on the following:

QUESTION: What is the most appropriate mechanism for CMS to enforce price transparency requirements? Should CMS require hospitals to attest to meeting requirements in the provider agreement or elsewhere? How should CMS assess hospital compliance? Should CMS publicize complaints regarding access to price information or review hospital compliance and post results? What is the most effective way for CMS to publicize information regarding hospitals that fail to comply? Should CMS impose civil money penalties on hospitals that fail to make standard charges publically available as required by section 2718(e) of the Public Health Service Act? Should CMS use a framework similar to the Federal civil penalties under 45 CFR 158.601, et.seq. that apply to issuers that fail to report information and pay rebates related to medical loss ratios, as required by sections 2718(a) and (b) of the Public Health Service Act, or would a different framework be more appropriate?

We believe a potential first step the CMS could take would be to determine how hospitals are complying with 2718(e) of the Public Health Service Act. That language provided that hospitals could "either make public a list of their standard charges (whether that be the chargemaster itself or in another form of their choice), or their policies for allowing the public to view a list of those charges in response to an inquiry." In a survey regarding price transparency policies that received feedback from 78 finance leaders representing 185 hospitals the vast majority indicated that they are responding to inquiries when requested by patients (Houk, S., Cleverley, J. "How hospitals approach price transparency." hfm, Sep. 2014, pp. 57-62). Similar to this, the CMS could develop questions for hospitals to first understand the ways in which providers are complying with 2718(e). Penalties should not be created or enforced at this time.

RESPONDING TO THE CMS

The following information provides direction from the IPPS proposed rule for commenting:

DATES: Comment Period: To be assured consideration, comments must be received at one of the addresses provided in the ADDRESSES section, **no later than 5 p.m. on June 25, 2018.**

ADDRESSES: In commenting, please refer to file code CMS-1694-P. Because of staff and resource limitations, we cannot accept comments by facsimile (FAX) transmission.
Comments, including mass comment submissions, must be submitted in one of the following three ways (please choose only one of the ways listed):

1) Electronically. You may submit electronic comments on this regulation to http://www.regulations.gov. Follow the "Submit a comment" instructions.

   ***Search for CMS-1694-P and select "Comment Now" from search results*

2) By regular mail. You may mail written comments to the following address ONLY:
   Centers for Medicare & Medicaid Services, Department of Health and Human Services,
   Attention: CMS-1694-P,
   P.O. Box 8011,
   Baltimore, MD 21244-1850.

   Please allow sufficient time for mailed comments to be received before the close of the comment period.

3) By express or overnight mail. You may send written comments to the following address ONLY:
   Centers for Medicare & Medicaid Services, Department of Health and Human Services,
   Attention: CMS-1694-P,
   Mail Stop C4-26-05,
   7500 Security Boulevard, Baltimore, MD 21244-1850.

For information on viewing public comments, we refer readers to the beginning of the SUPPLEMENTARY INFORMATION section.